GASTRO CENTER OF NEW SMYRNA BEACH

PATIENT INFORMATION SHEET TODAY'S DATE _____

Patient Name _____ Date of Birth:___/___/____ Age_____

Local Address _____ Social Security # ___/_____/_____

City _____ State____ Zip Code_____ Home Phone # (___)_____-_____

Permanent Address_____ Cell Phone # (___)_____-_____

Martial Status: Single____ Married____ Widowed____ Divorced_____ Gender: M____ F____

Language _____ Ethnicity_____ Email _____

OCCUPATION _____ WORK TELEPHONE (___)_____-_____

PLACE OF EMPLOYMENT _____

SPOUSE'S NAME (SIGNIFICANT OTHER) _____ WORK TELEPHONE (___)_____-_____

PERSON TO CONTACT IN EMERGENCY _____ PHONE (___)_____-_____

PRIMARY PHYSICIAN _____ PHONE (___)_____-_____

REFERRING PHYSICIAN (if different from Primary) _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU HAVE MEDICAL INSURANCE? _____ YES _____ NO

PRIMARY INSURANCE CARRIER _____

NAME OF INSURED _____ MEMBER ID# _____

GROUP#_____ BIRTHDATE OF INSURED ___/___/____

EMPLOYER _____

SS # OF INSURED____ ___/___/____ RELATION TO INSURED _____

SECONDARY INSURANCE CARRIER _____

NAME OF INSURED_____ MEMBER ID# _____

GROUP #_____BIRTHDATE OF INSURED ___/___/____

SS# OF INSURED ___/___/____ RELATION TO INSURED _____

May we contact you at all phone numbers listed above? Yes____ No_____

May we leave your personal health information on your answering machine/voicemail? Yes____ No____

Special instructions:_____

Please list anyone you give permission to speak with us on your behalf.

Name: _____ Relation:_____

Would you like to receive emails from Gastro Center of NSB? Yes____ No_____

Patient Signature _____ Date:_____

Gastro Clinic of New Smyrna Beach

PATIENT GENERATED MEDICAL HISTORY

me: _____ DOB: _____ Date: _____

:P: _____ Referring: _____ Copies to: _____

armacy: _____ Pharmacy Phone #: _____

Directions: Please circle any of the following you have personally had during your life?

YOUR PAST MEDICAL HISTORY:

Asthma/Emphysema/COPD

Blood Transfusion Date: _____

Cancer:

Breast	Liver	Pancreas
Colon	Lung	Prostate
Esophagus	Ovary	Stomach
Other _____		Uterus

Congestive Heart Failure

Coronary Artery Disease

Crohn's Disease/Ulcerative Colitis

Diabetes Mellitus: Type 1 Type 2

GERD

High Blood Pressure

Irritable Bowel Syndrome

Liver Disease

Pancreatitis

Sleep Apnea

Ulcer Disease

Other_____

ALLERGY	REACTION

LAST MENSTRUAL PERIOD _____

Could you be pregnant? Y / N

YOUR PAST SURGICAL HISTORY:

	Date
Appendectomy	
Artificial Heart Valve	
Artificial Joint	
Bowel Obstruction	
Bowel (repair/resection)	
CABG/Heart Bypass Vessels _____	
C-Section	
Gallbladder Removal	
Hysterectomy Total Partial	
Neck Artery/Vascular Surgery	
Pancreas Surgery	
Surgery for Reflux/Hiatal Hernia	
Surgery for Ulcers	
Other _____	

MEDICAL PROBLEMS LIST/REASON FOR VISIT

_____

_____

_____

_____

YOUR SOCIAL HISTORY:

Occupation _____ Working / Retired

Tobacco? Y/N Type: _____

Qty: ____ Former____ Yr. Stopped ____

Alcohol: Y/N Drinks/Day _____ Social ____

Former_____ Yr. Stopped _____

Recreational Drug Use: Y/N Type:_____

Marital Status: M S D W L

Children #: Y/N Boys: _____ Girls: _____

Directions: Please circle any of the following that exists in your family.

YOUR FAMILY HISTORY:

TYPE	RELATIONSHIP	Paternal/ Maternal	AGE
Cancer, Breast	_____	P/M	_____
Cancer, Colon	_____	P/M	_____
Cancer, Ovary	_____	P/M	_____
Cancer, Uterus	_____	P/M	_____
Cancer, _____	_____	P/M	_____
Colon Polyps	_____	P/M	_____
Crohn's Disease	_____	P/M	_____
Gallstones	_____	P/M	_____
Liver Disease	_____	P/M	_____
Pancreatic Dis.	_____	P/M	_____
Ulcerative Colitis	_____	P/M	_____
Ulcers	_____	P/M	_____

Mother: Alive Y/N If no, cause_____

Father: Alive Y/N If no, cause_____

Sister: Alive Y/N If no, cause_____

Brother: Alive Y/N If no, cause_____

Other Diseases That Run In The Family: _____

_____

_____

Gastro Center of New Smyrna Beach- System Review

Patient name: _____ **DOB:** _____ **Today's Date:** _____

Please provide a brief explantion for today's visit:

Please check all that apply.

General

	Yes	No
Fatigue		
Chills/fever		

Head

	Yes	No
Headache		
Dizziness		

Eyes

	Yes	No
Double Vision		
Blurred Vision		

Nose

	Yes	No
Nasal Bleeding		
Nasal Congestion		

Throat

	Yes	No
Painful swallowing		
Difficulty Swallowing		
with liquids		
with solids		

Neck

	Yes	No
Pain/tenderness		
Noted masses		

Heart

	Yes	No
Chest pains		
Palpitations		

Lung

	Yes	No
Cough		
Shortness of Breath		

Gastrointestinal

	Yes	No
Vomiting Blood		
Rectal Bleeding		
Black Stool		
Blood in Stool		
Positive Hemoccult		
Vomiting		
Nausea		
Constipation		
Abdominal pain		
Heartburn		
Weight loss		
Loss of appetite		
Hemorrhoids		
Diarrhea		

Urology

	Yes	No
Blood in urine		
Painful urination		

Neurologic

	Yes	No
Weakness		
Seizures		

Musculoskeletal

	Yes	No
Back pain		
Limited mobility		

Psychiatric

	Yes	No
Depression		
Anxiety		
Increased stress		

PATIENT PRESCRIPTION LOG

PATIENT NAME:_____ DOB:_____

PHARMACY:_____ PHARMACY PHONE:_____

PHARMACY ADDRESS:_____

MEDICATION	DOSAGE	TIMES PER DAY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)**_____

Address:_____ **City/State/Zip:**_____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ **Facility Phone:**_____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip:_____

Dates and Type of information to disclose:

D 2 years prior from last date seen
D Dates Other:_____
D Specific Information Requested:
_____

The purpose of disclosure is:

D Change of Insurance or Physician
D Continuation of Care (e.g., VA Med Ctr)
D Referral
D Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Gastro Center of New Smyrna Beach/Dr. Antonio DeCarli

Address: 1722 State Road 44

City, State, Zip: New Smyrna Beach, Florida 32168

D **Please mail records.**
D **Please fax records.**

Fax: 1-386-333-6457 **Phone:** 386-427-0390

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**_____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

Gastro Center of New Smyrna Beach

Antonio DeCarli, M.D.

1722 State Road 44, New Smyrna Beach, FL 32168 • phone 386-427-0390 • fax 1-386-333-6457 www.gastrocenterofnewsmyrnabeach.com

FINANCIAL POLICY

Here at The Gastro Center of New Smyrna Beach we are fully committed to providing you with the best possible medical care. This written agreement is to inform you of our financial policy. It is vital that you are in clear understanding of our financial policy to maintain this professional relationship.

Office Visit – A scheduled appointment is a commitment of time between you and our practice, a time frame which we have reserved just for you. We understand that instances arise causing you to have to reschedule your appointment. If you are unable to keep a scheduled appointment, we ask that you please call to cancel/reschedule at least **24 hours** in advance to avoid a 20.00 service charge

Procedures- A scheduled procedure at one of the facilities that Dr. DeCarli reserves is a blocked, reserved time, with our physician, the facility, the facility staff, and the anesthesiologist. If you are unable to keep the date & time of your **scheduled** procedure, we ask that you notify us **no less than five days in advance** to avoid a 50.00 service charge. Cancelations within 48 hours of your reserved spot, or failure to show for a procedure will results in a 100.00 service charge.

Insurance: - We emphasize that your health is of the highest importance to us, regardless of your insurance. Please check with your insurance carrier to determine if we participate with your network and to identify any pre-existing requirements, limitations, or benefit restrictions that you may have prior to your appointment. If we do not participate with your insurance plan, **your payment in full** must be made at the time of your office visit. If we do participate with your insurance plan, we will file your claim and only request that you come to the office prepared to pay your co-pay and/or deductible on the day of your appointment. If you are a member of a HMO, you must take full responsibility for verifying that you have chosen a participating provider, and have the pre-requisites for your office visit in order to avoid being held financially responsible for any denied services.

Account Statements: Should it become necessary to bill you for services thought to be paid by your health insurance plan, payment is due upon your receipt of our billing statement. **Our office will not enter into dispute with your insurance company over their determination of your claims**. However, should you decide to exercise your appeal rights with your insurance company, we will provide any requested documentation to your insurance carrier. Unfortunately, we cannot delay the receiving of your payment for services that were rendered until you have reached a favorable outcome with your insurance. Account balances that are over 90 days old will result in having this account sent to the collection agency, and must be paid in full prior to your next appointment. If a scenario arises that will temporarily prevent you from paying your account balance, you must contact us promptly for assistance in the management of your account and the implementation of suitable payment arrangements.

Refunds and Account Inquiries: If your account has a credit balance, we will promptly release a refund check to you as soon as your insurance carrier has processed all pending insurance claims remaining on your account. Should you have a question regarding your account balance, please call our office at 386-427-0390.

_____ _____

SIGNATURE OF GUARANTOR DATE

GASTRO CENTER OF NEW SMYRNA BEACH

PATIENT INFORMATION SHEET TODAY'S DATE _____

Patient Name _____ Date of Birth:___/___/____ Age_____

Local Address _____ Social Security # ___/_____/_____

City _____ State____ Zip Code_____ Home Phone # (___)_____-_____

Permanent Address_____ Cell Phone # (___)_____-_____

Martial Status: Single____ Married____ Widowed____ Divorced_____ Gender: M____ F____

Language _____ Ethnicity_____ Email _____

OCCUPATION _____ WORK TELEPHONE (___)_____-_____

PLACE OF EMPLOYMENT _____

SPOUSE'S NAME (SIGNIFICANT OTHER) _____ WORK TELEPHONE (___)_____-_____

PERSON TO CONTACT IN EMERGENCY _____ PHONE (___)_____-_____

PRIMARY PHYSICIAN _____ PHONE (___)_____-_____

REFERRING PHYSICIAN (if different from Primary) _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU HAVE MEDICAL INSURANCE? _____ YES _____ NO

PRIMARY INSURANCE CARRIER _____

NAME OF INSURED _____ MEMBER ID# _____

GROUP#_____ BIRTHDATE OF INSURED ___/___/____

EMPLOYER _____

SS # OF INSURED____ ___/___/____ RELATION TO INSURED _____

SECONDARY INSURANCE CARRIER _____

NAME OF INSURED_____ MEMBER ID# _____

GROUP #_____BIRTHDATE OF INSURED ___/___/____

SS# OF INSURED ___/___/____ RELATION TO INSURED _____

May we contact you at all phone numbers listed above? Yes____ No_____

May we leave your personal health information on your answering machine/voicemail? Yes____ No____

Special instructions:_____

Please list anyone you give permission to speak with us on your behalf.

Name: _____ Relation:_____

Would you like to receive emails from Gastro Center of NSB? Yes____ No_____

Patient Signature _____ Date:_____

Gastro Clinic of New Smyrna Beach

PATIENT GENERATED MEDICAL HISTORY

me: _____ DOB: _____ Date: _____

:P: _____ Referring: _____ Copies to: _____

armacy: _____ Pharmacy Phone #: _____

Directions: Please circle any of the following you have personally had during your life?

YOUR PAST MEDICAL HISTORY:

Asthma/Emphysema/COPD

Blood Transfusion Date: _____

Cancer:

Breast	Liver	Pancreas
Colon	Lung	Prostate
Esophagus	Ovary	Stomach
Other _____		Uterus

Congestive Heart Failure

Coronary Artery Disease

Crohn's Disease/Ulcerative Colitis

Diabetes Mellitus: Type 1 Type 2

GERD

High Blood Pressure

Irritable Bowel Syndrome

Liver Disease

Pancreatitis

Sleep Apnea

Ulcer Disease

Other_____

ALLERGY	REACTION

LAST MENSTRUAL PERIOD _____

Could you be pregnant? Y / N

YOUR PAST SURGICAL HISTORY:

	Date
Appendectomy	
Artificial Heart Valve	
Artificial Joint	
Bowel Obstruction	
Bowel (repair/resection)	
CABG/Heart Bypass Vessels _____	
C-Section	
Gallbladder Removal	
Hysterectomy Total Partial	
Neck Artery/Vascular Surgery	
Pancreas Surgery	
Surgery for Reflux/Hiatal Hernia	
Surgery for Ulcers	
Other _____	

MEDICAL PROBLEMS LIST/REASON FOR VISIT

_____

_____

_____

_____

YOUR SOCIAL HISTORY:

Occupation _____ Working / Retired

Tobacco? Y/N Type: _____

Qty: ____ Former____ Yr. Stopped ____

Alcohol: Y/N Drinks/Day _____ Social ____

Former_____ Yr. Stopped _____

Recreational Drug Use: Y/N Type:_____

Marital Status: M S D W L

Children #: Y/N Boys: _____ Girls: _____

Directions: Please circle any of the following that exists in your family.

YOUR FAMILY HISTORY:

TYPE	RELATIONSHIP	Paternal/ Maternal	AGE
Cancer, Breast	_____	P/M	_____
Cancer, Colon	_____	P/M	_____
Cancer, Ovary	_____	P/M	_____
Cancer, Uterus	_____	P/M	_____
Cancer, _____	_____	P/M	_____
Colon Polyps	_____	P/M	_____
Crohn's Disease	_____	P/M	_____
Gallstones	_____	P/M	_____
Liver Disease	_____	P/M	_____
Pancreatic Dis.	_____	P/M	_____
Ulcerative Colitis	_____	P/M	_____
Ulcers	_____	P/M	_____

Mother: Alive Y/N If no, cause_____

Father: Alive Y/N If no, cause_____

Sister: Alive Y/N If no, cause_____

Brother: Alive Y/N If no, cause_____

Other Diseases That Run In The Family: _____

_____

_____

Gastro Center of New Smyrna Beach- System Review

Patient name: _____ **DOB:** _____ **Today's Date:** _____

Please provide a brief explantion for today's visit:

Please check all that apply.

General

	Yes	No
Fatigue		
Chills/fever		

Head

	Yes	No
Headache		
Dizziness		

Eyes

	Yes	No
Double Vision		
Blurred Vision		

Nose

	Yes	No
Nasal Bleeding		
Nasal Congestion		

Throat

	Yes	No
Painful swallowing		
Difficulty Swallowing		
with liquids		
with solids		

Neck

	Yes	No
Pain/tenderness		
Noted masses		

Heart

	Yes	No
Chest pains		
Palpitations		

Lung

	Yes	No
Cough		
Shortness of Breath		

Gastrointestinal

	Yes	No
Vomiting Blood		
Rectal Bleeding		
Black Stool		
Blood in Stool		
Positive Hemoccult		
Vomiting		
Nausea		
Constipation		
Abdominal pain		
Heartburn		
Weight loss		
Loss of appetite		
Hemorrhoids		
Diarrhea		

Urology

	Yes	No
Blood in urine		
Painful urination		

Neurologic

	Yes	No
Weakness		
Seizures		

Musculoskeletal

	Yes	No
Back pain		
Limited mobility		

Psychiatric

	Yes	No
Depression		
Anxiety		
Increased stress		

PATIENT PRESCRIPTION LOG

PATIENT NAME:_____ DOB:_____

PHARMACY:_____ PHARMACY PHONE:_____

PHARMACY ADDRESS:_____

MEDICATION	DOSAGE	TIMES PER DAY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)**_____

Address:_____ **City/State/Zip:**_____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:_____ **Facility Phone:**_____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip:_____

Dates and Type of information to disclose:

D 2 years prior from last date seen
D Dates Other:_____
D Specific Information Requested:
_____

The purpose of disclosure is:

D Change of Insurance or Physician
D Continuation of Care (e.g., VA Med Ctr)
D Referral
D Other_____

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This information may be disclosed and used by the following individual or organization:

Release To: Gastro Center of New Smyrna Beach/Dr. Antonio DeCarli

Address: 1722 State Road 44

City, State, Zip: New Smyrna Beach, Florida 32168

D **Please mail records.**
D **Please fax records.**

Fax: 1-386-333-6457 **Phone:** 386-427-0390

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**_____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

Gastro Center of New Smyrna Beach

Antonio DeCarli, M.D.

1722 State Road 44, New Smyrna Beach, FL 32168 • phone 386-427-0390 • fax 1-386-333-6457 www.gastrocenterofnewsmyrnabeach.com

FINANCIAL POLICY

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Procedures- A scheduled procedure at one of the facilities that Dr. DeCarli reserves is a blocked, reserved time, with our physician, the facility, the facility staff, and the anesthesiologist. If you are unable to keep the date & time of your **scheduled** procedure, we ask that you notify us **no less than five days in advance** to avoid a 50.00 service charge. Cancelations within 48 hours of your reserved spot, or failure to show for a procedure will results in a 100.00 service charge.

Insurance: - We emphasize that your health is of the highest importance to us, regardless of your insurance. Please check with your insurance carrier to determine if we participate with your network and to identify any pre-existing requirements, limitations, or benefit restrictions that you may have prior to your appointment. If we do not participate with your insurance plan, **your payment in full** must be made at the time of your office visit. If we do participate with your insurance plan, we will file your claim and only request that you come to the office prepared to pay your co-pay and/or deductible on the day of your appointment. If you are a member of a HMO, you must take full responsibility for verifying that you have chosen a participating provider, and have the pre-requisites for your office visit in order to avoid being held financially responsible for any denied services.

Account Statements: Should it become necessary to bill you for services thought to be paid by your health insurance plan, payment is due upon your receipt of our billing statement. **Our office will not enter into dispute with your insurance company over their determination of your claims**. However, should you decide to exercise your appeal rights with your insurance company, we will provide any requested documentation to your insurance carrier. Unfortunately, we cannot delay the receiving of your payment for services that were rendered until you have reached a favorable outcome with your insurance. Account balances that are over 90 days old will result in having this account sent to the collection agency, and must be paid in full prior to your next appointment. If a scenario arises that will temporarily prevent you from paying your account balance, you must contact us promptly for assistance in the management of your account and the implementation of suitable payment arrangements.

Refunds and Account Inquiries: If your account has a credit balance, we will promptly release a refund check to you as soon as your insurance carrier has processed all pending insurance claims remaining on your account. Should you have a question regarding your account balance, please call our office at 386-427-0390.

_____ _____

SIGNATURE OF GUARANTOR DATE